

**SHARE PROGRAM PARTICIPANT
REGISTRATION FORM**

Business or Individual Name: _____

Address: _____

Nature of Business: _____

Contact Person: _____

Contact Person Email: _____

Contact Person Telephone: _____

Number of Employees (if business): _____ Number of AEDs: _____

AED Manufacturer/Model _____

Number of Individuals to be trained initially in the use of the AED: _____

Training to be conducted by: _____

Desired Start Date: _____ / _____ / _____

As a participant in the SHARE Program I can expect medical direction and QI service at no cost and I agree to the SHARE Program requirements listed below:

1. Provide documentation of training on request;
2. Maintain names of all individuals trained in AED use;
3. Provide manufacturer of all AEDs purchased;
4. Provide information and event data from device for all AED uses; and
5. Provide name and contact information for medical director if other than the BEMS medical director is selected.

Date Submitted: _____

Date Approved: _____

Please fax completed form to:
Lani Clark at (520) 626-2201.